PROGRESS

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IN THIS ISSUE

AWARENESS · KNOWLEDGE · UNDERSTANDING
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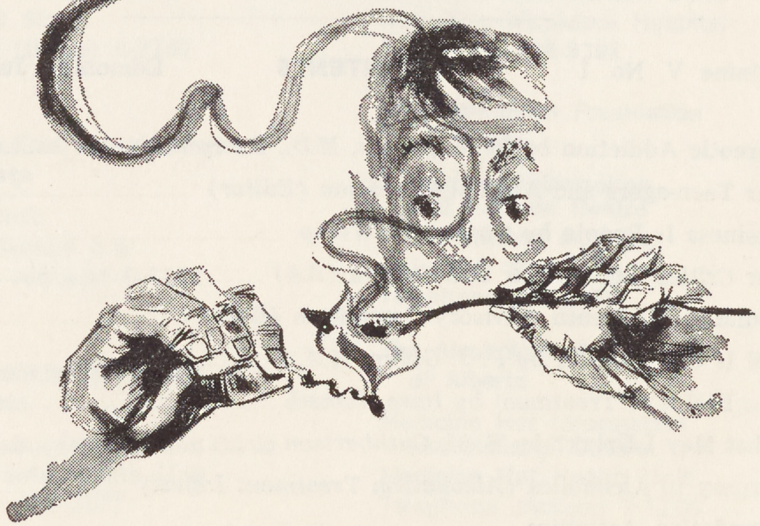
Narcotic Addiction



MEDICAL

SOME THOUGHTS ON PRESENT PROGRAMS AND FUTURE NEEDS

by S. J. HOLMES, M.D., D.Psych.

Dr. Holmes has had considerable experience with drug addiction, serving as consultant to the Drug Addiction Clinic at Mimico Reformatory from its inception in 1957 until June, 1962. An expert in alcoholism as well, Dr. Holmes has worked with the Adiction Research Foundation in Toronto since 1950; the Alex G. Brown Memorial Clinic from 1957 to 1962; the Shadowbrook and the Bell Clinic from 1948 until 1956. In addition to his private practice in Toronto, he is a clinical teacher in psychiatry at the University of Toronto. Dr. Holmes has also worked with the Department of Veterans' Affairs at Sunnybrook Hospital since 1947.

THE PROBLEM of narcotics and narcotic addiction is a worldwide situation that involves many countries to varying degrees, from varied points of view, for example from production, export, manufacture, trafficking and addiction, and with many varied socio-cultural influences.

Narcotic addiction in Canada, in terms of numbers, is small when compared, for example, with that in the United States. However, when it is viewed as a part of a total social disorder, then it takes its place proportionately with other chemical relationships or deviant behavior patterns. Over the past seven or eight years, there has been very little change in the total narcotic addict population as reported by the Narcotic Control Branch of the Department of National Health and Welfare. In 1961, there was a total of 3,395 addicts in Canada known to the Narcotic Control Branch, and these are divided into 3,048 criminal, 224 medical and 123 professional addicts.

It would appear that there has been a gradual reduction over the years in the medical and professional addicts with a corresponding rise in the criminal addict group. It has been estimated by the Addiction Research Foundation of Ontario that there is one narcotic addict to eight non-narcotic addicts to every 100 alcoholics. In Canada, the narcotic addict population is found related to three centres, namely Vancouver, Toronto and Montreal, with appropriate figures of 1,872, 913 and 316 addicts in the order of the city mentioned. These figures must be accepted as minimal and only by further epidemiological studies will we arrive at a more realistic numerical, geographical and social picture.

Ambivalent Approach

The approach to the problem in Canada at the present time shows considerable ambivalence but does not appear to be influenced as militantly by punitive thinkers as appears to be the present attitude in the United States as compared to the more humane orientation in Great Britain. While it is true, and indeed often quoted to varied interpretations, that the laws in Great Bri-

tain, United States and Canada with regard to narcotic control are not basically different, this really is only part of the story. While there is no definite "British System" of handling the narcotics addict, there is nevertheless a difference in fundamental philosophy between the medical and legal experts in Great Britain and that to be found on the continent of North America.

In Great Britain when they say that narcotic addiction is a medical disease, they mean just that and leave the treatment decisions, both short-term and long-range, strictly in the hands of the medical doctor. The legal people maintain an interested—but in the main, a hands-off policy — on such registered addicts undergoing therapy.

Recently, a change has become evident in the attitude of the Canadian public towards people who develop addiction. We are showing more understanding and tolerance of the addict, and there is almost a popular demand for treatment facilities for all addictions. Our views on handling the problem are becoming more medically oriented, and fewer people are inclined to think only of penal servitude facilities for the treatment of narcotic addiction.

Important Changes

In 1961 two major events occurred from a Canadian point of view. The first was Canada's leadership in the Single Convention on Narcotic Drugs aimed at International Control. (For further details of this I would refer you to Mr. Curran's excellent article in the November, 1961 issue of 'Medical Services Journal of Canada' — Volume 17, Number 10, as well as Mr. Macdonald's article in 'Current Law and Social Problems 1960 and 1961'.) The second was an enactment by the Parliament of Canada of a bill, known as the Narcotic Control Act, which was introduced by the Minister of Justice in co-operation with the Minister of National Health and Welfare. This new act replaces the Opium and Narcotic Drug Act which had been in force since 1919.

In this new act, a number of important changes in the previous system of control and enforcement have been made. These have been designed to permit the legislation to be more effective in achieving two purposes: (1) to facilitate the availability of narcotic drugs for medical and scientific use; and (2) for the effective supervision of the illicit narcotic traffic. Added to the latter, this new bill contains a new provision and procedure relative to the treatment of narcotic addicts which is thought to offer, for the first time, a realistic and humane approach to this problem.

The Narcotic Control Act became law September 15, 1961, but the treatment proviso is not effective until treatment facilities are organized. At present, the first of what may be three 450 bed units is under construction in the interior of British Columbia, and its possible opening date is early 1963. I understand there are plans in the future for a similar unit in the Toronto and Montreal areas.

Proposed Treatment of Addicts

In the new legislation, a person convicted of an offense under the Act, and diagnosed prior to trial as an addict, may, on the first offense, be sentenced to treatment for an indefinite period up to seven years, and on a second offense, be placed under treatment supervision for what could be the rest of his or her life. In accordance with the penitentiaries system, the government has indicated that special facilities or institutions as mentioned before, will be set up for the reception and accommodation of addicts who are so sentenced. These persons will be given such treat-

ment as experience may indicate is required, released on parole and subject to statutory supervision for an indeterminate period. If they relapse they can be returned for further custody and treatment.

It would appear that the experience of the United States with a similar program but without a follow-up parole period at the Lexington and Fort Worth hospitals has been very disappointing. A relapse rate of some 90 per cent has been reported, which is much the same as the experience to date that I have seen in my experience up to May, 1962, at the Drug Addiction Clinic operated since 1956 by the Ontario Department of Reform Institutions at Mimico Reformatory. To date we have seen about 300 male addicts there during the last three months or so of their sentence. One of the main stumbling blocks in the rehabilitation of these patients has been the lack of parole, as well as community facilities to which the patient can be referred. It is my opinion, at the risk of being classified as a pseudo-expert, that this type of institution has a very limited use from a treatment as well as a research point of view.

The Community Clinic

Much more vital in the treatment of this addiction is the community clinic located in the cities where the addict has been living and where the various social, family, legal and medical factors can be integrated in a more realistic and appropriate manner. This is far more promising than transporting the patient, under sentence, to a remote treatment area from which he will later be discharged to a community—either the one whence he came or one where the incidence of addiction is predicted to be low and therefore "safer" but without any real facilities for his needs. In this way, it would seem to me there is a great need for the getting together of persons of experience and interest from the fields of legal, social and medical science to develop a more balanced approach to this many-sided problem.

Addiction—A Crime or A Disease?

To date, there has been a tendency for people of experience or interest in this question to become proponents of this or of that point of view. Consequently, there is little agreement and people often become committed to a particular point of view which really indicates their ignorance of the total problem. As yet, it would seem to me that there is much conflict as to whether narcotic addiction is a crime or a disease—or a little of both, depending on whether we are dealing with professional, medical or so-called criminal addicts. The classical example of this appears to be the conflict in the United States between the Narcotics Bureau and the joint American Medical Association and American Bar Association Committee. The former looks upon narcotic addiction as a crime; the latter regards it is a disease. As yet, the problem is unresolved.

In Canada there would appear to be more acceptance of the disease concept among many interested people, but there continues to be a variance in police, legal and medical areas about policies with regard to dealing with this problem. Thus at the present time, it would appear that the 'problem of narcotic addiction' is disproportionately greater than the number of people it involves as addicts.

The reasons for this would appear to be:

(1) The tremendous impact which the narcotic drugs have on the human organism psychologically and physiologically; and the interest this creates in all those who are, for scientific, artistic or pathological reasons, concerned with exceptional states of mind.

(2) The challenge which this phenomenon constitutes for the middle class North American value system; and the socio-legal situation which this challenge has created on this continent.

(3) The challenge which it constitutes for science, especially for the medical and social sciences and allied professional disciplines.

(4) The struggle for control of the narcotic field between law enforcement, scientific, political and social groups, and the underworld and their very different interests, which, at present, immobilizes effective social action.

Principles to Consider

In addition to the federal institutions it would appear, as mentioned before, that both research and treatment units should be established in cities where narcotic addicts are found in substantial numbers. In this, the following principles should be considered:

(1) The narcotic addiction problem has to be solved, or at least a beginning has to be made, in a given social (medico-legal) atmosphere. The vested interests and particular views of those already involved in the problem have to be understood and evaluated. In this it is most desirable to avoid taking sides in the existing ideological controversy about addiction.

(2) The narcotic addiction problem is as yet not sufficiently explored, especially as a many-sided problem, from the point of view of the total personality of the addict, and as a total social phenomenon. At least part of the research should be focussed on treatment methods, taking into consideration all the relevant aspects of the problem as an interacting system — pharmacological, psychiatric, legal and sociological.

(3) There is no existing treatment method which is at present an unqualified success. Thus, a great deal of social, medical and psychiatric inventiveness and an experimental attitude is needed in this area.

(4) The whole effort should be made in such a way that research and treatment would continuously have a bearing on each other. The different treatment experiments should be continuously evaluated and modified.

Existing Treatment Approaches

The present existing approaches to treatment could be put into four categories:

(1) Punitive—This approach is reflected in severe mandatory sentences, vigorous law enforcement and "cold turkey" treatment—this is a most inhuman treatment in the light of present knowledge. Sadly, I must report that in Canada this still remains the approach most commonly used.

(2) Correctional — This involves probation and parole and within this framework different schemes like the experiment of the New York parole department, which concentrates on working with families; the Oakland experiment, which is a combination of probation with nalline tests; and the present Canadian thinking of long sentences with early release on parole.

(3) Hospitalization — This medical-psycho-social treatment used exclusively in closed institutions like Lexington, Forth Worth, New York's Riverside Hospital, Oakalla and the D.A. Clinic at Mimico, is limited because it includes no organized aftercare program. Somewhat similar are those programs of voluntary or committal forms of treatment in mental hospitals under the Provincial Mental Health Act.

(4) Ambulatory-Medical — This approach is strongly attacked in some of its forms on this continent. The accepted form is that of the Narcotic Addict Foundation of British Columbia, where withdrawal and

follow-up, through relapses if necessary, is done with the option of the clinic to insist on the patient's taking Lorfan as a test for the presence of narcotics when indicated. In this type of approach, it seems to me we are unthinkingly following the treatment pattern used in instances of alcohol and other non-narcotic drug addictions as if they were similar when, in fact, there is a great difference psychologically, socially, physiologically and legally.

Lady Frankau's Results

The type of treatment clinic unaccepted on this continent at present is that reported by Lady Frankau in England. There, the patient is stabilized and carried on a daily dose of narcotics during a period of social and occupational rehabilitation, with the eventual goal of carrying him on into drug-free relationships. The results of this experiment, as published in The Lancet in December 1960, cover a group of 51 patients treated between August, 1958, and March, 1960. There were nine medical, six non-criminal, 36 criminal types with all clear in the medical group; three clear, two on small doses intending to stop and the sixth apparently unlikely to stop in the non-criminal group; and of the larger group of 36, 20 are clear, 10 still under treatment and six have proved resistant. This type of approach is most refreshing and interesting with almost unbelievable results.

(5) Voluntary Non-Medical—This kind of approach is found in Narcotics Anonymous and Synanon Foundation in Santa Monica, California. The reports from the latter groups are rather encouraging.

Probably the most difficult problem is the question of coercion versus voluntary treatment. At the present time, it appears to be the opinion of the most responsible writers on the subject in North America that in the present social context, some coercion is desirable. This may prove to be valuable in getting the patient to face treatment earlier in the disease. However, further treatment plans should attempt to explore the possibilities in the cultural setting of all the voluntary medical and non-medical approaches, or possible combinations of these, for the greatest potential in rehabilitation of the addict. From the point of view of withdrawal, it would appear that we have worked out a satisfactory method which can be practised in a closed hospital setting, under medical supervision, with a minimum of discomfort and complication. In my opinion, every addict is entitled to such a humane withdrawal but this is still not done in many instances.

Most important, however, in the treatment of the addict is rehabilitation. In view of the psychological and social factors related to the addiction it is necessary that exploration of these start as soon as the addict enters a treatment situation. Rehabilitation includes:

(1) Vocational guidance and training or retraining for new occupations since a large percentage of addicts have never developed an adequate work pattern. Many experts point with emphasis to the fact that 90-95 per cent of the criminal group have shown criminal behavior prior to addiction which, in their opinion, practically closes the door to therapy—at least in these experts' minds. We must recognize, however, from the work of Sturrup in Denmark, that much can be attained in the rehabilitation of severe psychopathic personality disorders.

(2) Supportive social therapy — most addicts have inadequate recreational and social life. There should be a diversified program to include sports, motion pictures, dancing, reading and other indoor games, with special emphasis on

ego development in interpersonal relationships, with both sexes participating.

(3) Individual psychotherapy — where indicated, this should be aimed at the patient's personality needs.

(4) Spiritual therapy—with pastoral counselling this may lead to acceptable human relationships and to a philosophy that can be applied further in North American relationships and beyond in social integration.

(5) Group therapy in which there is mutual discussion of emotional problems and social participation with other patients, is used in order to fulfil the needs of the poorly motivated patient.

A full follow-up with inclusion of the patient and other members of his family, where necessary, is essential in therapy.

The Addict and His Family

In the management of the addict and his family, it is necessary to study the patient in this milieu as a whole from the point of view of the heredity and constitutional factors, the development of the personality, and its reactions to the environment. Analysis of the patient's reactions, and the dynamic factors involved, helps them to achieve the ability to deal with anxieties, to understand and accept these limitations, and to tolerate emotions which arise from frustration. Insight is not enough. They must try to control and strengthen personality weaknesses, for security must be based on self-reliance combined with the ability to become an integrated member of society.

In this approach, the attitudes of both the patient and the members of the treatment team play a most important role. The fact that the attitude of many addicts may be pretty negative toward life without drugs, and the fact that the relapse rate is very high, should be expected and accepted rather than looked on with disdain or with criticism of the patient. We cannot realistically ask that the addict never

use drugs again; but we can ask and expect him to go to work and in this way build a new pattern of living.

Most addicts are quite ambivalent in their desires with regard to drugs. They have a desire to stop using, which was remarked on in terms of its high frequency, in a recent Canadian Medical Association Journal article by Martin and Dancey. We can strengthen this desire by acceptance and understanding at all times, whether initially or during relapse, and in this way put the onus for his behavior on him. Present attitudes of rejection, punishment, kicking his habit "cold turkey", all help the addict to expiate his guilt feelings and make relapse more acceptable to him, as well as a return to the acceptance he finds in his sub-culture of drug addicts down at the "corner".

Prevention and Education

From the point of view of prevention, a program of appropriate education with regard to drugs of all kinds should begin at the school level, including both the medical school and the grade school. While the large proportion of narcotic addicts have poor school records, they are curious and read a lot. Many have said they might not have been overcome with curiosity at the tales about drugs if they had known more about them in the first place.

We must develop a sound approach to the problem of juvenile delinquency, of which drug addiction is only a facet along with alcoholism, criminal and other anti-social behavior. In the light of our present knowledge, the commonest and most disastrous conditions leading to delinquency are those centered about the family life. In this, the potential delinquent is one who at some stage of his development has been blocked in his needs for a satisfying relationship in the family. Unfortunately, emphasis is still placed on protecting society and not in the fuller development of individuals who show early signs of not becoming integrated satisfactorily. It is my concept that a comprehensive treatment and rehabilitation unit for narcotics addicts must be centered in, and have a close relationship with, all aspects of community life. It is in the community that addiction begins, and it is there that it must be treated and prevented.

The Problem of Contagion

Another factor in prevention is from the point of view of contagion. It has been accepted that this illness is spread from an addict to the potential addict through identification, curiosity, daring, the need to be accepted, to belong and so on. This assures status for the addict as well as a supply of drugs. It has been proposed that clinics where the addict is maintained on drugs reduces his need to be at the corners where others can relate to him, and to the black market, thus reducing the development of new addicts as well as reducing illicit trade. Such reports have been coming from Britain, where the addict can get his drugs when necessary from doctors, and although these theories have been attacked by American writers, they would certainly bear some consideration.

Much Research Needed

A very great emphasis must be placed on the need for further research in the field of narcotic addiction—psycho-social, bio-chemical and physiological. There is much need for study of the natural history of addiction in individual addicts, with attention to both the social and personal factors related to the development of the disorder. The social factors in the epidemiology also need further study. Evaluation studies must be built into all treatment and rehabilitation programs,

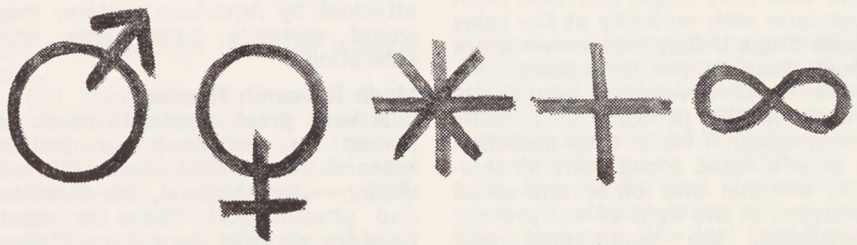
especially in evaluating the many contradictions which have developed in various areas with regard to statistics, and methods of treatment, types of patients, agencies best suited for referral, and so on.

In conclusion, a program for control of narcotic addiction requires a determined enforcement of laws against distribution, possession and sale by non-addicts. This should be accompanied by a co-ordinated program in which there are a number of closely integrated elements, ranging from a penal setting through to a program of intensive and continued after-care in the community. Throughout, emphasis should be placed on the experimental pilot character, with intended diversification of interest and emphasis of these programs at this stage, and of the very great need for epidemiological research and well designed evaluation studies so that we may have some idea of what we are doing and how effective we are being. Our choice of approach should be our own, patterned on what we can learn from American, British and other European approaches, but comprised of the fact that our culture is not directly identified with any of these patterns.

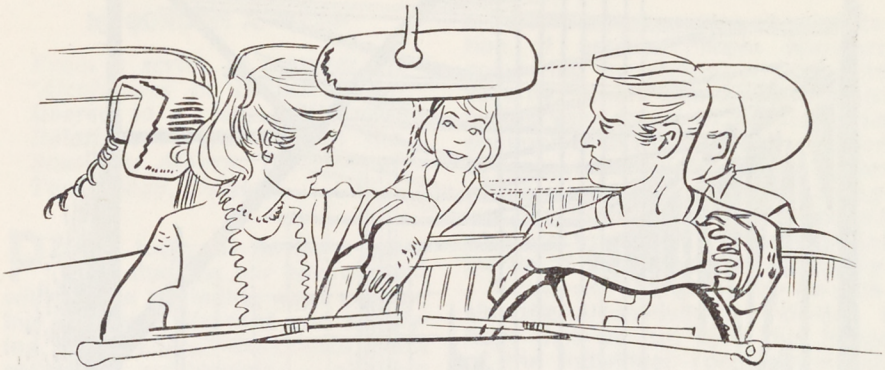
Must Be Objective

Let us refrain from reacting to public anxiety, political crises, and legal pressures relative to the lack of knowledge of dealing effectively with the narcotic problem and thus be precipitated into unfortunate experiments such as have occurred in the past. Rather, let us maintain an open mind and sift the evidence as it develops, in an objective manner that will enable us to progress in a responsible and reasonable way, over the long term studies of the life history of the addicts and the cycle of addiction.

Reprinted by permission, this article originally appeared in Addictions, Winter, 1962 edition.



OUR TEEN-AGERS AND ALCOHOL EDUCATION



In view of the growing concern over the incidence of alcoholism, particularly as it relates to teen-agers, it was gratifying to observe the recognition accorded this subject by the Alberta Federation of Home and School Associations during the course of their annual meeting held at the Macdonald Hotel, Edmonton, on April 27, 1963.

The appointment of a committee to study the problem was effected by this special resolution:

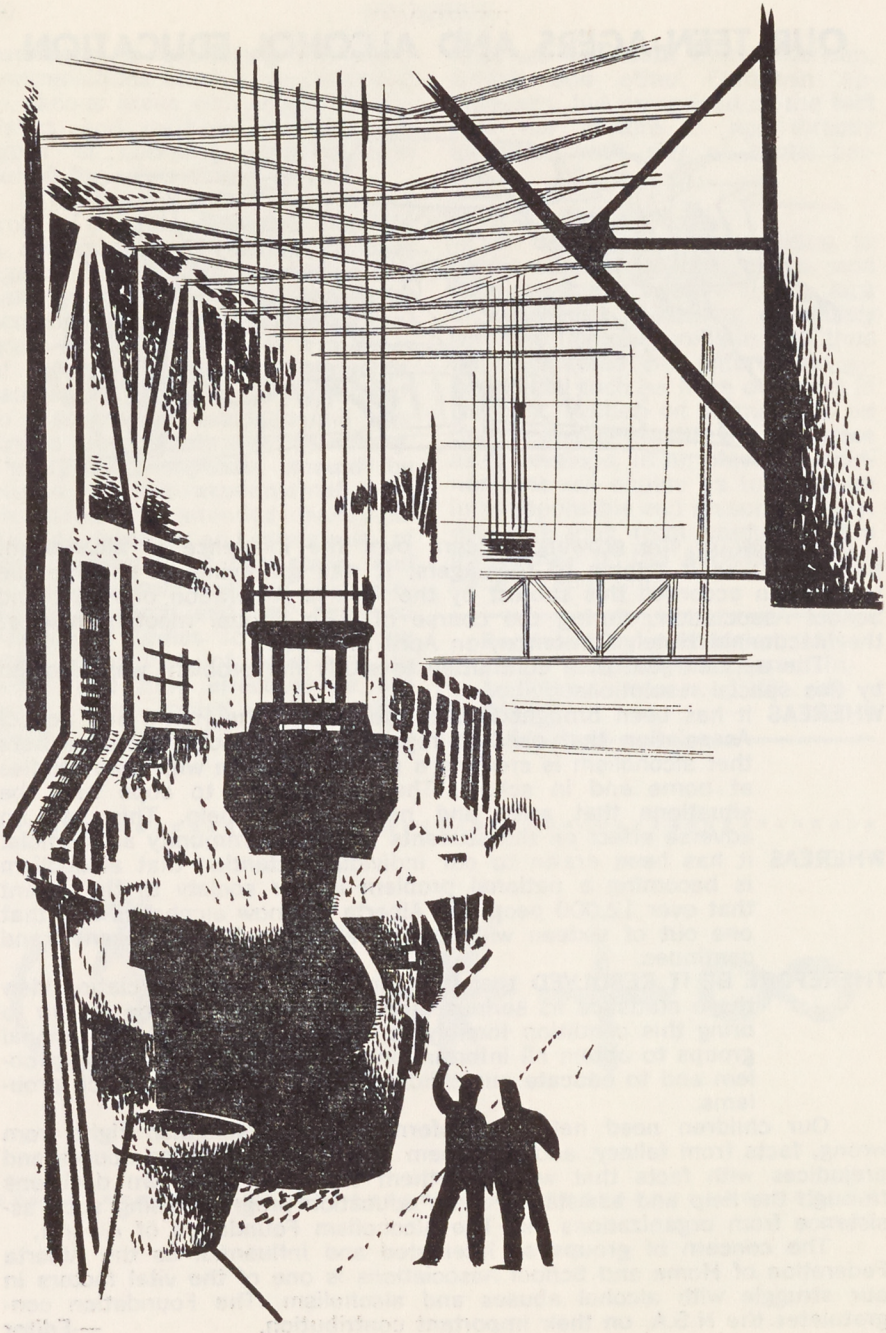
WHEREAS it has been brought to the attention of the Home and School Association that children report to the principal and teachers that alcoholism is creating a serious problem with their studies at home and in school. They are unable to cope with the situations that arise and need outside help. This has an adverse effect on the students and the community as a whole.

WHEREAS it has been drawn to our individual attention that alcoholism is becoming a national problem in our society to the extent that over 12,000 people in Alberta are now alcoholics and that one out of sixteen will become alcoholic if the present trend continues.

THEREFORE BE IT RESOLVED that the Home and School Association view these statistics as serious, and that a committee be set up to bring this condition forcibly to the attention of all Educational groups to obtain all information and facts relative to this problem and to educate our children how to handle just such problems.

Our children need help and information to distinguish right from wrong, facts from fallacy, and give them knowledge to replace doubts and prejudices with facts that will help them to make their own decisions through the help and assistance of an education program, using such assistance from organizations like The Alcoholism Foundation of Alberta.

The concern of groups as interested and influential as the Alberta Federation of Home and School Associations is one of the vital factors in our struggle with alcohol abuses and alcoholism. The Foundation congratulates the H.S.A. on their important contribution. —Editor



BUSINESS IS PEOPLE

by GORDON A. WEMP

From a series of lectures on 'Alcoholism in Industry', delivered to a class in 'Human Relations in Industry' at the Southern Alberta Institute of Technology, Calgary.

PEOPLE today are having a grand time studying our environment with a view to finding ways of making life more pleasant and satisfying. Researchers, economists, town planners, sociologists — all are gathering mounds of data on suburbia, urban renewal, industrial planning, trade, transportation and, in fact, every facet of our modern way of life. The wise researcher in these fields is aware that—no matter how many neat figures and facts he gleans—he is basically doing a study in human relations.

Human relations might be described simply as 'the interaction of the individuals in the community'. If we use this definition in looking at the Industrial Community, we must remember that, as in any other community, its functions are influenced by the strengths and weaknesses of the people within it. I say "if" we use this definition. For when we consider the industrial community in this light, there is a danger of overfocusing on those aspects with which we are most familiar—the hierarchy, the chain of command, the status of position and committee rule, among others. Therefore, I prefer to use the definition of a top industrial consultant, A. O. Malmberg, who declared to the Vancouver Chamber of Commerce some years ago that 'Business is People'.

'Business is People'! Think of what this means! The community that we have attempted to fit into a pattern now becomes an aggregation of people! People who are competing for status, position and security; people who are threatened by the very nature of the industrial community in which they had hoped to gain security; inflexible people who are unable to cope with changing conditions; and flexible people who are frustrated by the apparent inertia of the industrial community.

Since we are going to be considering Alcoholism in Industry, I hope that we can keep this image of the individual (people) in our minds. It is not enough to talk about the situations, problems and conditions without considering the human factors that have such an influence on the community. With this in mind, let's have a look at the industrial atmosphere that affects—and is affected by—the alcoholic employee.

Under today's rapidly changing economic and trade conditions in commerce and industry, business executives are faced with finding new methods of production, sales, distribution, automation and general procedures. At the same time, cost factors dictate more economical use of personnel along with retraining and relocation programs. And, in the face of these new business methods, the labor force (another community) is justly concerned with job security and opportunity. A certain unease is evident, and for the most part management has found it prudent to move with caution where the welfare of the employee is concerned. Fortunately, at least in Canada, enough co-operation exists between business and labor to permit frank discussions on how these new conditions are to be met, and the responsibilities of each group in making this transition with the least possible upset. For the

most part, business is aware of the fact that our labor force—our people—is our most important resource and asset.

Such consideration is bound to benefit a fair majority of the people involved in commerce and industry. Nevertheless, there are people who present special problems which must be dealt with on an individual basis. There are the handicapped; the elderly; the disabled workers; the unstable workers; the uneducated; and, among others, the chronically ill. In the latter category are those with such illnesses as diabetes, epilepsy, arrested or cured tuberculosis and alcoholism. In this presentation, it is alcoholism with which we are concerned. We propose to show that, although the person with alcoholism is most certainly chronically ill, and may appear to be a liability to the firm concerned, he can nevertheless be restored to a productive place in the industrial community.

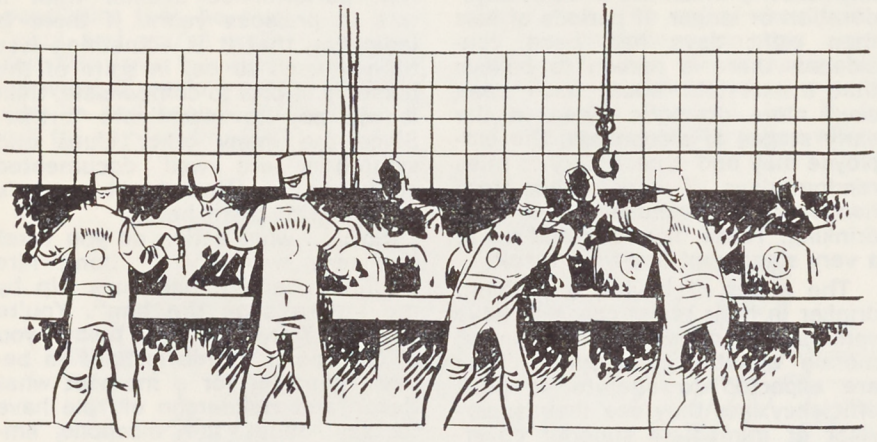
What is the size of the problem? The only criterion that we have at the moment is the formula developed by Dr. E. M. Jellinek. Using this yardstick, in Alberta there are very conservatively, twelve thousand active cases of alcoholism, and we must assume that a significant proportion of these people are involved in commerve and industry. It is almost impossible to obtain an accurate estimate of the cost to society of the alcoholism illness. However, there is reason to believe that the total cost in dollars and cents runs to millions of dollars per year in Alberta. Mr. Sidney Katz, associate editor of Maclean's, claims with some justification that the cost in Canada exceeds $100,000,000 per year. Much of this cost is at the expense of commerce and industry, through absenteeism, high scrap rate, accidents, reduced work efficiency, lowered morale, decreased productivity, and many other factors. Most of these are hidden factors that have a very real effect on cost control, and on the health of the industrial community — hidden for the very reason that the alcoholic worker is able to hide his illness for many years.

Why is the person with alcoholism able to cover up his condition so effectively for so long a time? A study reported by Dr. Milton Maxwell may hold some of the answers. It would seem to indicate that the person with alcoholism has a great deal of co-operation in covering up the drinking problem. Although forty four percent of respondents in the study claimed they received no assistance from fellow employees in covering up, a similar number **had** received co-operation from a variety of fellow-workers, including their supervisors! A number of methods were employed in this collaboration. Some superiors ignored the condition, thus ruling out any corrective action. Others made excuses or told outright lies to their superiors to account for the poor work record of the alcoholic employee. An even larger group of fellow employees helped to maintain secrecy by assisting him in avoiding contact with his superiors and even in hiding out until he was in better condition.

The results of this line-management collaboration are evident when we note that in each case executive management felt that the incidence of alcoholism in their industry was insignificant, whereas over seventy-five percent of the supervisors believed that the rate was two percent or higher.

In the light of the fairly common picture that the public has of 'the alcoholic', it is perhaps understandable that management failed to recognize the extent of the problem. The 'skid road' stereotype is the one that comes to mind when one speaks of 'the alcoholic'. He is

regarded as being a 'moral degenerate', 'a burden on society', 'the town drunk', a person who beats his wife, neglects his family, spends his days—and nights—in the bar; an individual who can't be trusted with even the simplest matters, who can't hold a job; and as someone who is in constant trouble with the law.



In actual fact, of course, the very reverse is likely true. The alcoholic employee may never have committed anything more serious than a parking violation; he is a family man, who is loved by his wife and children (although they may be concerned about his drinking); he's never been involved with another woman, or stayed away from home overnight; on the job, he works hard, and may even put in overtime to make up for the odd time when he was absent with 'Monday-morning 'flu'. His drinking may be so subdued that his fellow employees are unaware that he takes a drink, let alone that he has a problem. Between 'covering up', and the fact that the early-stage alcoholic is hard to detect by the untrained, it is small wonder that management is inclined to underestimate the incidence of alcoholism in business.

It would seem then, by failing to recognize the serious proportions of the problem, that management is also unaware of the high cost of alcoholism in industry. And the cost is high. In another study of problem drinkers by Dr. Maxwell, medical records of one company disclosed some very startling information. In comparing a problem group of employees to a control-group, it was revealed that the problem drinkers had two and a half times as many cases of illness or injury-related absence lasting eight days or more, as did the control-group. Considering male employees only, the problem drinkers had nearly three times as many days absent as the male control-group members. Sickness payments for the male problem drinkers were three and a half times as large as those paid to the male members of the control-group. In the case of the women, the ratio was about two to one. In other words, in terms of sickness payment only, the problem drinkers cost almost three times as much as the controls, (non-problem drinkers and abstainers).

Regarding accidents, on and off the job, the total number recorded by the problem drinkers was 3.6

times as large as that of the controls. Briefly then, the problem drinkers in this study were absent two and a half times as many days, cost three times as much in sickness benefits, and had 3.6 times as many accidents as the matched controls.

Note that the study we have just discussed deals with absences (for any reason) which are of eight days' duration or longer. If periods of less than eight days had been considered, there is reason to believe that the results would have been even more dramatic. Even in the early stages of alcoholism, the employee may find it necessary to miss random days of work, either from hangover or because he is still drinking. These days can add up to a very significant lost-time result.

The effect of having a problem drinker in their midst can also have serious consequences in the lowered morale of other employees. They are expected to operate at peak efficiency, yet they see their supervisor or immediate superior covering up for an obviously inefficient alcoholic employee. Lowered morale means reduced productivity, higher scrap rate, discontent with working conditions, higher accident rate and inferior products. If the problem drinker happens to be at the executive or management level, his whole area of responsibility suffers, and yet management may be inclined to look elsewhere for the trouble, seeking out causes where they do not exist. And, of course, it's easy to overlook the source of the trouble since this whole process occurs so slowly, over a period of years, that the change goes unnoticed.

The key to solving the problem in one's own business lies in recognizing alcoholism for what it is—an illness, in being able to detect one's own alcoholic employees, and knowing what to do about it. As for recognition, we could make this appear to be a very complex problem, whereas in many cases, management could discover who their alcoholic employees are simply by asking their supervisors.

This accounts for the obvious cases, but what about those people who are in the earlier stages and are more difficult to detect? The secret here is to balance off current performance against what it was in previous years. If there is indication that it is something less than it used to be, in spite of the person's efforts to compensate, then it will pay to investigate further. Since the many other clues and symptoms are well documented elsewhere, no attempt will be made to deal with them here.

So . . . what action do you take? You may well say, "I don't hire alcoholics, and if one does slip by me I darn soon fire him". You're so right! You DON'T hire them—you GROW them! If this is hard to believe, consider for a moment what Bacon and Henderson of Yale have to say about the alcoholic employee: Most alcoholics in industry are valuable veterans of twenty years' experience. "Sixty percent have held the same job for three years or more; fifty percent for seven years or more; twenty-five percent for ten years or more."

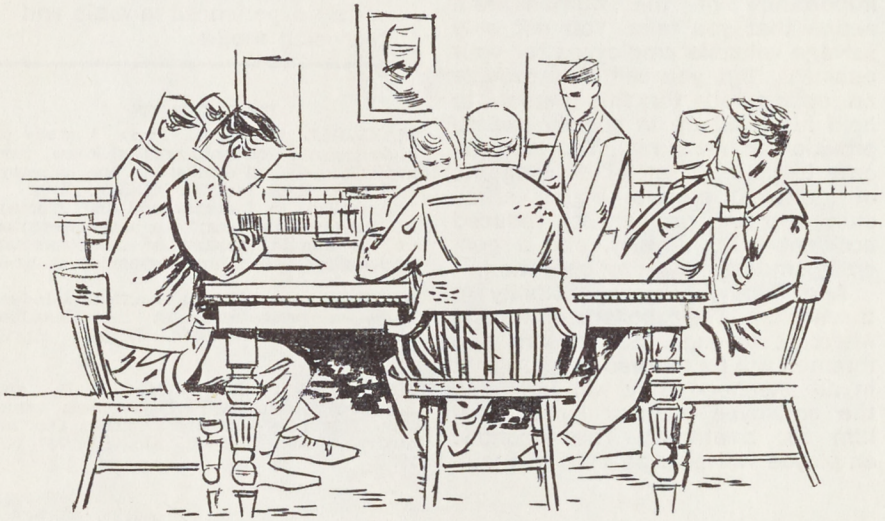
You, as management, want to do the right thing—the thing that will benefit the most people. However, you find that it's pretty hard to be objective about a person who is seriously disrupting your operation. Here are a few things which you can consider about the alcoholic employee that will help to clarify the matter in your own mind:

You hired him (or somebody did), because he had talents that you wanted.

He was intelligent, loyal, a hard worker, ambitious, a self-starter, honest, reliable (the sort of person you need in your operation),

and likely still is.
He is a family man and he needs YOU.
He may be a hard man to replace, because of the nature of his work. He likely doesn't drink on the job.
You have a big investment in him. It's going to cost you real money to train another man.

These facts don't rule out the possibility that he may also be a 'slob' and you're well rid of him. But this isn't too likely, because if he were, it would be hard to justify why he had been kept on the payroll for any length of time.



You perhaps agree that firing the employee is not the answer, and in fact it may be extremely expensive. If nothing else, one must consider the cost of re-hiring and training, along with the general disruption in the department concerned. There are some steps that can be taken to deal with those alcoholics you may have now, and to protect yourself in the future. It is essential first to recognize that alcoholism is an illness—an illness that is treatable, even under duress. Next, the company should establish policy and procedure that would create an atmosphere to encourage the alcoholic employee to come forward for treatment. (Policy costs nothing, and may save you money.)

In addition to regarding alcoholism as an illness, the policy should explain how the company will aid the alcoholic employee, setting out the specifics of how this will be accomplished. The policy should also set the limitations on this aid—stating how far the company will go before considering discharge. It is important too, to let it be known that no punitive action will be taken, unless an employee refuses treatment or if treatment is unsuccessful. It should also be stated explicitly that covering up a case of alcoholism by other personnel constitutes a serious breach of policy, and will be dealt with by strict disciplinary measures. In order to remove the stigma from the alcoholism illness, the company's medical scheme should not make any distinction between alcoholism and any other illness that comes under the scope of the plan. Finally, and

possibly most important, executives and supervisory staff must be oriented to the alcoholism illness concept so that they can recognize it when they see it, and deal with it effectively.

We have suggested that there are some real benefits in instituting such a program. What do you actually gain? First of all, you gain respect—respect of your employees, of the labor unions, of the medical profession, of the rest of the business community including customers, and of the alcoholic employee himself.

There is no need to minimize the importance of the humanitarian action that you take. You not only salvage valuable employees for your business, but you will also provide an opportunity for this person to hold his head up in society and to provide for his family. You also accrue to yourself, all of the benefits of improved morale—higher efficiency, improved productivity, reduced accident rates, loyalty, and a generally smoother-running operation.

And finally, the responsibility in the matter of alcoholism now rests where it belongs. Supervisors and foremen will be relieved to know that in all likelihood they will be doing the employee a favor by sending him for treatment. The alcoholic employee will also be able to maintain his dignity and integrity by voluntarily seeking help under a plan that is not punitive, but rather, therapeutic. This is Human Relations at its best—individual interaction that seeks to preserve human dignity and basic rights, while at the same time providing every opportunity for free expression and maximum growth.

Gordon A. Wemp serves on the Calgary staff of The Alcoholism Foundation of Alberta as Information Officer. He specializes in both lay and professional educational work, and is widely experienced in radio and television media.

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Total abstinence is easier than perfect moderation.

—St. Augustine

Ninth
Annual

Progress Report

SUMMARY

Period:
January 1, 1962
December 31, 1962

THE ALCOHOLISM
FOUNDATION OF ALBERTA

Provincial Administrative Centre: 9929 - 103 Street, Edmonton

1962

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THE ALCOHOLISM FOU

615 NEW PATIENTS

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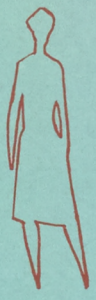

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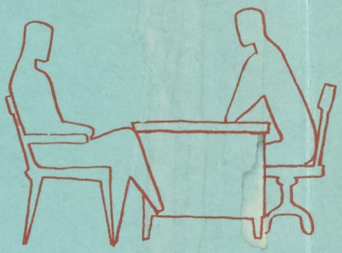


9,533 INTERVIEWS

TREATMENT

657 GROUP THERAPY SESSIONS

PROGRESS TRENDS
1953 - 62

Recovered or Improved
55%

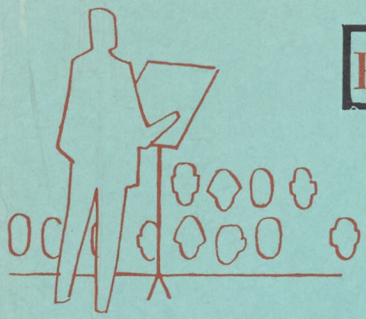
Unimproved
33%

Under Active Treatment
12%

THE YEAR'S ACTIVITIES

FOUNDATION OF ALBERTA

1962

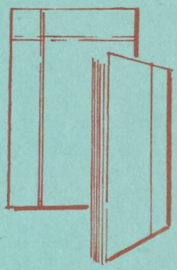


EDUCATION

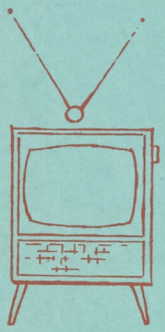
306 PUBLIC TALKS, MEETINGS
AND SEMINARS
7,700 ATTENDANCE

25,809 PIECES OF LITERATURE
DISTRIBUTED

SOCIAL AGENCIES
CHURCHES
DOCTORS
NURSES
INDUSTRY
SCHOOLS
MAGISTRATES
POLICE
GENERAL PUBLIC



24,967 PERIODICALS
DISTRIBUTED



RADIO & TV PROGRAMS

RESEARCH

COMPLETED AND CONTINUING STUDIES

e.g. Skid Row Delineation
Male Drinking Patterns
Causes of Patient Death
Distribution of Consumption Outlets
Social Perception of Female Patients
Beverage Alcohol Sales and Consumption
Drinking Problems in an Ethnic Minority
Confiscation of Liquor and Interdiction
CPI Characteristics of Recovered Patients

Application for Membership in
THE ALCOHOLISM FOUNDATION OF ALBERTA

By becoming a member of The Alcoholism Foundation of Alberta, you can actively support its work of treatment, education and research. Any person who donates five dollars or more, in cash or services, becomes a member. Members receive all Foundation publications and can vote at all membership meetings. Without membership donations we could not carry out the special educational programs, staff training, or research projects which are so urgently required to reduce this major socio-medical problem.

Please send your donation to one of The Foundation's centres:

Edmonton	Lethbridge	Calgary
9929 - 103 St.	The Glenwood Bldg. 321 - A6 Street South	737 - 13 Ave. S.W.

Please enroll me/us as a member of The Alcoholism Foundation of Alberta for twelve months. Enclosed is a membership donation of

$_____.

Name_____

Company or Group_____

Address_____

Please apply my donation to:

- ☐ General Fund
- ☐ Preventive Services — including
  - Special Educational Projects
  - Professional Training
  - Community Services
- ☐ Research Projects
- ☐ Staff Training

The annual government grant supports the treatment program and much of the educational activities of The Foundation. The essential development of our preventive and research programs, however, does depend on membership donations and the United Community Funds of Edmonton and Calgary.

All membership contributions are tax deductible.

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OUR CRITICS CAN BE OUR BENEFACTORS

(A recent magazine article criticizing certain aspects of AA reminds us of the need to review the relation we have to medicine, to religion and to the world at large. In this connection Bill W., when the Grapevine editors consulted him on the matter, suggested a rereading of relevant portions of "AA Comes of Age" (published in 1957) and "Twelve Concepts for World Service" (published in 1962). Here, Bill suggested, members and friends may find helpful guidance. Bill has directed particular attention to the excerpts quoted below.—Ed.)

AS A SOCIETY we must never become so vain as to suppose that we have been the authors and inventors of a new religion. We will humbly reflect that each of AA's principles, **every one of them,** has been borrowed from ancient sources. We shall remember that we are laymen, holding ourselves in readiness to co-operate with all men of good will, whatever their creed or nationality.

Speaking for Dr. Bob and myself, I would like to say that there has never been the slightest intent, on his part or mine, of trying to found a new religious denomination. Dr. Bob held certain religious convictions, and so do I. This is, of course, the personal privilege of every AA member.

Nothing, however, could be so unfortunate for AA's future as an attempt to incorporate any of our personal theological views into AA teaching, practice or tradition. Were Dr. Bob still with us, I am positive he would agree that we could never be too emphatic about this matter.

Then, too, it would be a product of false pride to believe that Alcoholics Anonymous is a cure-all, even for alcoholism. Here we must remember our debt to the men of medicine. Here we must be friendly and, above all, open-minded toward every new development in the medical or psychiatric art that promises to be helpful to sick people. We should always be friendly to those in the fields of alcoholic research, rehabilitation, and education. We should endorse none especially but hold ourselves in readiness to cooperate so far as we can with them all. Let us constantly remind ourselves that the experts in religion are the clergymen; that the practice of medicine is for physicians; and that we, the recovered alcoholics, are their assistants.

There are those who predict that Alcoholics Annoymous may well become a new spearhead for a spiritual awakening throughout the world. When our friends say these things they are both generous and sincere. But we of AA must reflect that such a tribute and such a prophecy could well prove to be a heady drink for most of us—that is, if we really came to believe this to be the real purpose of AA, and if we commenced to behave accordingly. Our Society, therefore, will prudently cleave to its single purpose, the carrying of the message to the alcoholic who still suffers. Let us resist the proud assumption that since God has enabled us to do well in one area we are destined to be a channel of saving grace for everybody.

On the other hand, let us never be a closed corporation; let us never deny our experience for whatever it may be worth to the world around us. Let our individual members heed the call to every field of human en-

deavor. Let them carry the experience and spirit of AA into all these affairs, for whatever good they may accomplish. For not only has God saved us from alcoholism; the world has received us back into its citizenship. Yet believing in paradoxes as we do, we must still realize that the more the Society of Alcoholics Anonymous as such tends to its own affairs and minds its own business, the greater will be our general influence, the less will be any opposition to us, and the wider will be the circle in which our Fellowship will be likely to enjoy the confidence and respect of men.

Now let us suppose that AA does fall under sharp public attack or heavy ridicule; and let us take the particular case where such pronouncements happen to have little or no justification in fact. Almost without exception it can be confidently estimated that our best defense in these situations would be no defense whatever—namely, complete silence at the public level. Unreasonable people are stimulated all the more by opposition. If in good humor we leave them strictly alone, they are apt to subside the more quickly. If their attacks persist and it is plain that they are misinformed, it may be wise to communicate with them in a temperate and informative way; also in such a manner that they cannot use our communication as a springboard for fresh assault. Such communications need seldom be made by the Conference officially. Very often we can use the good offices of friends. Such messages from us should never question the motives of the attackers; they should be purely informative. These communications should also be private. If made public, they will often be seized upon as fresh excuse for controversy.

If, however, a given criticism of AA is partly or wholly justified, it may be well to acknowledge this privately to the critics, together with our thanks.

In the years ahead we shall, of course, make mistakes. Experience has taught us that we need have no fear of doing this, providing that we always remain willing to confess our faults and to correct them promptly. Our growth as individuals has depended upon this healthy process of trial and error. So will our growth as a fellowship. Let us always remember that any society of men and women that cannot freely correct its own faults must surely fall into decay if not into collapse. Such is the universal penalty for the failure to go on growing. Just as each AA must continue to take its moral inventory and act upon it, so must our whole society do if we are to survive and if we are to serve usefully and well.

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The greatest of faults, I should say, is to be conscious of none.

—Thomas Carlyle

FOUNDATION'S YOUTH ADVISORY COMMITTEE RENDERING VALUABLE SERVICE

The Youth Advisory Committee, currently numbering ten boys and girls, representing various Edmonton Teen organizations, was formed in May, 1961, to establish useful liaison between city youth groups and The Alcoholism Foundation of Alberta.

Subsequent semi-monthly meetings with The Foundation's educational and public relations staff members served to acquaint The Foundation with Teen attitudes on drinking specifically, and on related educational and social problems generally. And by the inevitable process of change and drop-out, these meetings also served to eliminate those members with only casual and transient interests, and have left us with an active, alert and informed group of young people.

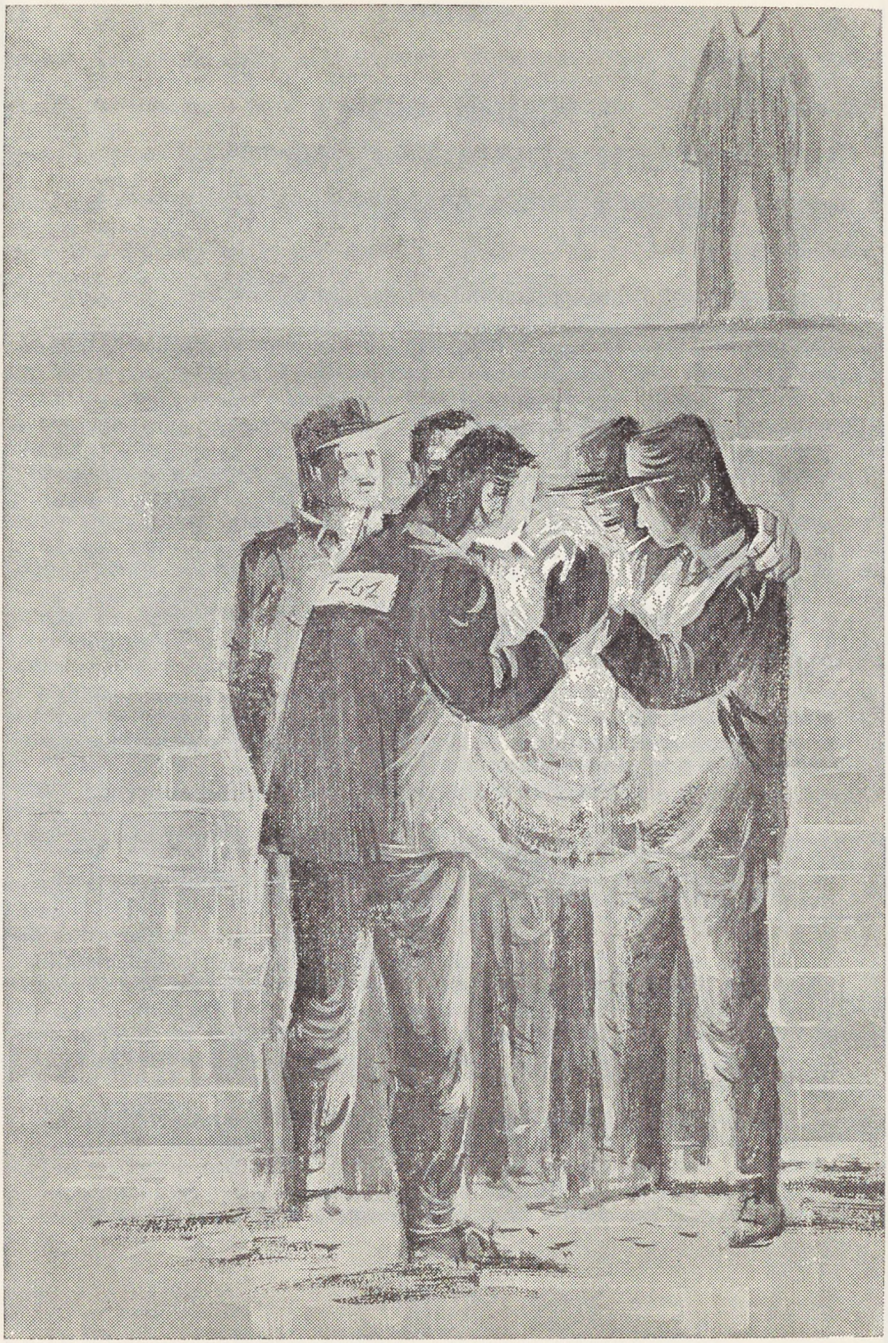
Besides functioning in a generally advisory capacity, these boys and girls have helped edit and revise The Foundation's youth pamphlet 'Looking at Alcohol'.

In the fall of 1962, the Youth Advisory Committee undertook an intensive Speakers' Bureau training program, consisting of four weekly three-hour seminars at The Foundation. All members participated in this program under the instruction and guidance of a member of The Foundation's Educational Services Department.

Upon completion of the seminars these boys and girls arranged speaking engagements for themselves in various Teen groups throughout the city. The Foundation will continue to give them guidance and support in this very worthwhile and expedient undertaking.

Most recently, the Youth Advisory Committee has undertaken, with The Foundation's Research Department, an inquiry into specific areas of teen-age drinking behaviour. The Committee contributed to the framing of a useful questionnaire in this connection and is assisting the Research Department on a continuing basis in this study.

Slated for the Youth Advisory Committee's next assignment is a plan to produce a pilot (exploratory) film on teen-age drinking attitudes. This will be done on 8 mm. film under the direction of Foundation personnel. Its success may lead to other film productions covering the whole area of teen-agers and alcohol.—Editor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JAIL

IS OFTEN BETTER THAN LIFE OUTSIDE FOR THE CHRONIC DRUNKENNESS OFFENDER

by P. J. GIFFEN, M.A.

Mr. Giffen, an associate professor of sociology at the University of Toronto, is directing the Attorney-General's special project studying chronic drunkenness offenders. This article is slightly revised from a lecture he gave at the Summer Course on Alcohol Problems, sponsored by the Addiction Research Foundation at the University of Toronto, in June, 1962.

IN TORONTO and in most large communities in North America, you can find a considerable group of men who are in and out of jail repeatedly for public drunkenness. Last year, some 18,000 cases were heard in Toronto's Court "G", the Magistrate's Court which handles public drunkenness cases that occur within the city limits. These appearances were accounted for by some 10,970 individuals, of whom 3,000 were there twice or more and some of whom appeared more than ten times in the year. We know that once a man has entered the revolving door, he may continue in it for decades, and actually serve hundreds of jail sentences.

It is also known that the statistical probability of a man's emerging from the revolving door is very small. Treatment facilities such as the Harbour Light Mission, the Alex G. Brown Memorial Clinic, A.A. and the Addiction Research Foundation Clinic only manage to salvage a few from a relatively large population. Although we don't know exactly how many of these men there are in Ontario, 5,000 individuals is probably a conservative estimate.

The remarks that follow will have to do with some of the sociological characteristics of this population as observed in a large urban centre. The situation in smaller communities may differ considerably. The problem is aggravated in a city like Toronto by the existence of a well-developed system of hostels, missions and other facilities for homeless men, so that it tends to become a mecca for men of this type from smaller communities and other parts of Canada. We have found that no more than 20 per cent of the chronic drunkenness offenders in Toronto grew up in the city. A large number come fromother places than Ontario and somewhere between 20 and 30 per cent from the Atlantic Provinces. Once a chronic drunk finds his way to Toronto's Skid Row, he is likely to stay.

Few Alcoholics Hit Skid Row

Three characteristics of this group deserve special mention. The first is the fact that they differ from the majority of alcoholics in our society in their vulnerability to arrest. Estimates of the proportion of the alcoholics in our society who are involved in the revolving door may vary from three per cent to 12 per cent. Secondly, most of these men are alienated from conventional social relationships and memberships to a striking degree—the term "undersocialization" is sometimes used to refer to this phenomenon. Thirdly, they are participants in

what we can call a deviant social system; they are the drinking segment within the Skid Row society.

Arrest and Incarceration

In our society it is regarded as offensive, if not dangerous, to allow people to stagger around the streets drunk or lie stretched out in doorways. Both the law and public opinion create the expectation that the police will "keep the streets clean". The offence is not simply being intoxicated but being intoxicated in a public place, which means that men who have no home in which to drink, or no family or employers to protect them are more likely to be in the streets and are thus more likely to be arrested. The more often they are arrested, the less likely they are to have access to a private place in which to do their drinking. Moreover, they are more likely to appear in a highly policed downtown area and to be highly visible because they are ill-dressed and unkempt.

Although the law was changed in 1961 to do away with the mandatory jail term for repeaters, the net effect was still very much the same. The majority of chronic offenders are unable to pay a fine of any magnitude, so they must serve the alternative jail sentence in any event. Many of them continue to spend more time in jail than they do outside. The threat of imprisonment obviously serves little or no deterrent function for men of this type, since they have a higher rate of recidivism than any other type of offender.

The policies of the police play an important role in determining who enters this population and how rapidly the revolving door goes around. In some places, the police follow a policy of containment, as they do on New York's Bowery, where men tend to be left alone as long as they confine their activities to that area. The police in Toronto are believed by Skid Row men to be unusually zealous. Our own observations are that even in Toronto, only a small percentage of the people who are drunk in the downtown area on weekends are picked up. If an intoxicated person looks as if he can get home under his own steam, and is unlikely to come to any harm, he may not be arrested. The chronic drunkenness offender, even if he is not known to the police, appears to be a man who likely has no home to go to and will end up sleeping where he falls. The decision of the police to arrest is, in effect, an adjudication of guilt, because drunkenness offenders almost invariably plead guilty when they appear in court. The empirical probability of a case being dismissed in the drunk court in Toronto is one in 500.

The high probability of arrest in Toronto, and of going to jail once arrested, helps to perpetuate this way of life. It shortens sprees and means that the men spend a large part of their time in jail where they have no liquor, but do have a healthy diet and regular hours. Thus, they are, in some degree, protected from the more severe physical consequences of prolonged drinking. This also means that they do not have to worry about the consequences of going on an almost constant binge when they are out of jail and of eating little or nothing, because they know that they will soon be back inside.

Become "Socialized" to Jail

The frequent jailing of these men seems to have a cumulative effect. They become accustomed or "socialized" to the jail society, so that if it ever had a strong deterrent effect, it wears off over time. They learn to adjust to jail with the minimum of distress, to do "easy time". A man may even acquire a right to a certain job within the jail which he will perform each time he returns. The job may carry with it a

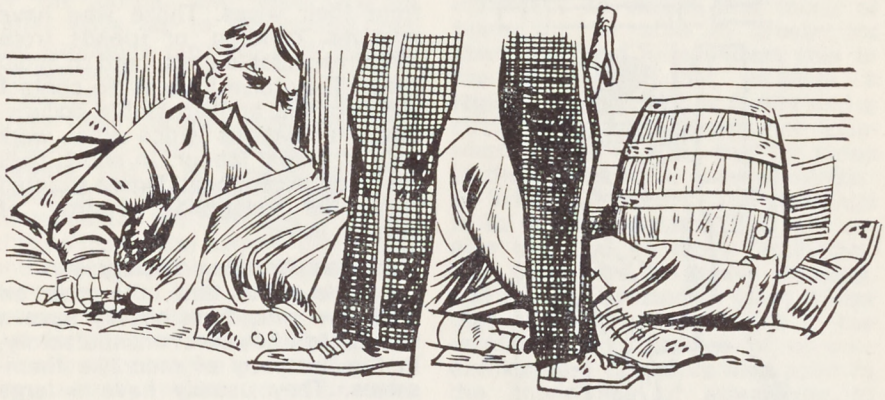
certain amount of recognition and minor privileges, in contrast to his low status and anonymity in the larger society.

From the viewpoint of the authorities in the large urban jail, most chronic drunkenness offenders are good prisoners. They are tractable, uninterested in escaping, and reliable workers. Their occupational reliability within the jail is something of a paradox, since most of them seem to be uninterested in working outside of jail. In general, the jail staff are likely to have a more favourable view of drunks than the other authorities, and to treat them accordingly. The police see them drunk and obstreperous, the courts see them in a deferential role and probably in a poor state because of their drinking bout, and the operators of Skid Row facilities see them as a particularly troublesome element within the population of homeless men.

Many of the chronic drunkenness offenders have had earlier experiences that have prepared them for living in an all-male institutional setting. Quite a few of them have previously been in lumber camps, railroad gangs, the merchant marine, and the armed services, and few of them have become accustomed to, or dependent on, domestic life. A considerable number have had experience in reformatories and penitentiaries at an early age. In all these settings, they tend to be under authority and have few decisions to make for themselves, so it is not difficult for them to become acclimatized to jail life.

Some Men Prefer Jail Life

This does not mean that the men will admit that they like jail; such an admission seems to threaten their self-respect. But they are much less critical of the jail staff than of any other authorities with whom they are in contact, and they will admit that there are many other men who are "crashers"—men who deliberately expose themselves to arrest in order to get into jail.



When the punishment aspect of jail is assessed we have to think in terms of relative deprivation. For a middle-class person, being in jail is a pretty catastrophic experience, since he is cut off from his family, his job, his friends and is socially stigmatized. When we compare jail life to the life outside for the Skid Row man, we realize that the painful consequences are relatively much lighter. He is already stigmatized since he is at the bottom of the social scale, and his conditions of life outside tend to be chaotic

and uncomfortable. He sleeps in missions, doorways, boxcars, or, occasionally, rented rooms, and when he eats, if he eats at all, the meals are usually of a poor quality. When these men describe their daily round when they are drunk, there is some-

thing of a nightmare quality. Jail is not, in relative terms, a bad place.

It is particularly significant that when these men are in jail, very few of them, according to their testimony, feel a craving for alcohol, except during the initial period when they are suffering from withdrawal. They say that they do not think much about drinking as long as they are in jail. Much of the energy and ingenuity that went into finding alcohol on the outside, is directed toward getting cigarettes, special food, and other minor privileges in the jail. Many of them are talented manipulators within their familiar and circumscribed settings.

Alienation from Normal Society

By the time these men are in the revolving door, most of them are cut off from the main relationships and satisfactions that we regard as important. Many of them have never married, and those who have are separated or divorced from their wives. Those who have relatives, children, or friends from more respectable days, tend to avoid them. They have little or no contact with women, and no stable occupational affiliations since they work only at casual labour. In short, they are to an exceptional degree isolated from the relational rewards of normal living.

Skid Row Drinking Society

At the same time, the men on Skid Row who drink heavily have a substitute, however unsatisfactory, in the company of men like themselves. They usually have a large number of acquaintances in the same boat, men they have met when drinking, in jail, in parks, in hostels and so on. This group is deviant because its code of behaviour differs from accepted standards. The group norms are focussed on getting alcohol, arranging for others to share the drinking of it, and avoiding arrest. A surprisingly large amount of the drinking is social. A man may take his first drink of the day alone, particularly if he is "sick", but he will then seek companionship for his drinking, and might even postpone his drinking for a considerable time until he rounds up company. There are strong norms of reciprocity and an etiquette of drinking with which all the participants are familiar.

It is a highly specialized and unstable sub-culture. The "bottle" groups are loose formations. In a single day, one man may pass through several groups. The groups are always in a state of flux and movement, and there are no recriminations if a man moves from one group to another, and no questions are asked if he suddenly appears to join one. They tend to avoid highly aggressive people who will get them into trouble, and they resent "boomers", that is, those who take more than their share of the bottle, and men who in other ways fail to reciprocate. But the sanctions are few, and memories are short.

Although the men constantly denigrate their surroundings and their companions when talking to interviewers, this is all they have. Their deviance is rewarded by social acceptance and the company of equals shields from from slights, criticisms, and rejection. However, their dependence on Skid Row companions increases the cost of going straight. Not infrequently, they make sporadic attempts to give up drinking but they usually return to their Skid Row friends when isolation becomes unbearable.

Can They Be Rehabilitated?

One of the virtues of half-way houses for men of this type is that they try to provide the solidarity and mutual dependence of Skid Row life, but at the same time change group norms so that attempts to stay dry and hold a steady job are supported and rewarded. Most of the welfare institutions of Skid Row unwittingly help to perpetuate the revolving door pattern since they help the men to meet their minimum physical needs without working, and without providing any effective means of motivating them or fitting them to break away from Skid Row.

However, it is probably misleading to think of rehabilitation of these men according to middle-class standards. Given their age and lack of occupational and social skills, it is unrealistic to expect that many of them will be able to create for themselves an independent role in the community that includes a regular job, a home, a family and a circle of friends. Experience elsewhere seems to show that for many of these men some form of sheltered living is inevitable. The challenge is to devise a system that will enable them to be more productive, less dependent on heavy drinking, and more interested in other things than they are when caught in the revolving door. Studies of chronic drunkenness offenders also point to the importance of attempting to rehabilitate these men at an earlier stage when they are younger and less alienated.

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The abuse of a thing is no argument against the use of it.
—Jeremy Collier

THE ETHICS OF TREATMENT

by IMRE NEMETH

Mr. Nemeth is a psychiatric social worker at the Addiction Research Foundation Clinic in Toronto.

IN THE 1962 summer issue of "The Humanist", Dr. Nathaniel S. Lehrman wrote an article in which he offers criticism of some of the present practices and attitudes in the mental health field. He begins by quoting Marie Jahoda to the effect that "one value in American culture compatible with most approaches to a definition of positive mental health appears to be this—an individual should be able to stand on his own two feet without making undue demands or impositions on others."[1] He distinguishes between organized activity against mental illness and the fostering of mental health itself. Then later, he comments "in view of the uncritical, almost reverent acceptance of these ideas and practices, they should be examined. Two moral questions seem of special significance. Does mental health sometimes tend to see man as more devoted to himself than to being his brother's keeper? Has mental health somehow helped inhibit the right freely to inquire?"

Dr. Lehrman charges that "in health the directions of physicians are usually taken on faith and the same is true in relation to mental health." Further, he says, some patients seem to be "harmed by previous psychotherapeutic contact." He describes a case where a marriage broke up because of the psychoanalyst's refusal to see the wife of the patient and accept her as well as the marriage as relevant to the treatment situation. He concludes that "moral neutrality is a rather important part of the mental health ideology."

Psychiatrists—Today's Clergymen?

"The psychiatrist," Dr. Lehrman goes on, "has acquired a rather awesome quality to many people. To them, he has become the unquestioned expert on what goes on within their own minds. In many ways, the psychiatrist of today fulfills the functions of the clergyman of yesterday. The moral laws under which psychiatrists actually seem to operate may determine the probable direction of the mental health movement itself." But, "although clergymen have recognized and grappled with moral and social conflicts throughout the years, psychiatrists and other mental health professionals tend to avoid them. Their primary orientation is towards reduction of pain, but as we have seen, this reduction of pain can appear without regard for either ethical consideration or the rights of others."

"The idea that laws and man are eternally in conflict, and that codes are therefore followed primarily because of fear, is scientifically unsound. The importance of adherence to moral codes from positive devotion is underestimated by both psychiatry and the mental health movement," Dr. Lehrman says. "The moral anarchy so pervasive in the mental health approach is frequently aggravated by its rather destructive attitude toward ideals and effort, toward thinking and heroism. The net effect of all these denigrating psychological studies is to deny that good really exists and to imply that individual freedom from anxiety, rather than social usefulness with its accompanying

stresses, should be the prime purpose of living."

Mental Health and Education

At the end of his article. Dr. Lehrman quotes the Group for the Advancement of Psychiatry regarding mental health education: "There is no conclusive evidence, they assert, that it prevents mental disorders or promotes mental health. Nor is there established evidence that it does not. However, the public belief that education for mental health is of value results in extensive public education efforts."

Dr. Lehrman concludes, "If these issues are confronted squarely, they can doubtlessly be solved. If they are not, however, mental health might run the risk of becoming a scientific-seeming moral fraud. Such an outcome in the present age of anxiety would hardly benefit either our country or mankind."

Ethics and the Tyranny of Experts

The criticisms which Dr. Lehrman directs against the mental health field and psychiatry in particular have to be seen in a proper context. Problems about ethical neutrality and the tyranny of experts are not peculiar to psychiatry alone but apply to our society as a whole. However, some professions are more exposed to them than others.

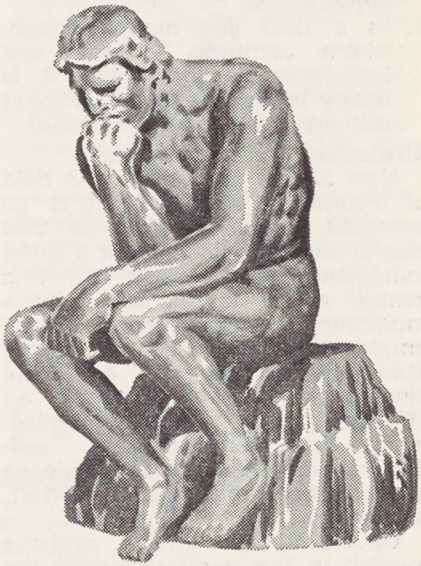
There are four general points which are important to remember:

First—that the whole Western world is in a "moral vacuum", since, to use Maslow's phrase,[2] neither religion nor the different ideas derived from the Enlightment have universal significance any more and the consequence is the prevalent moral relativism and pluralism.

Second, as Tawney pointed out, there is a characteristic Anglo-Saxon reluctance "to test the quality of an activity by reference to principles" and "to take fundamentals for granted."[3]

Third — that science, especially under the influence of postivism, has banished values from the realm of serious thought.

Fourth—that the most influential men who have shaped our attitudes in the social sciences, men like Max Weber and Sigmund Freud, were either advocating moral neutrality as a method of inquiry, or denying that morality is a problem for the clinician. Their followers took this as encouragement to give up concern for morals as unscientific.



The Problem of Morality

All these tendencies and attitudes are present to some extent on this continent, but there is an unusually strong concentration of them among the helping professions and the mental health movement. This situation presents several problems which could be summarized in the following points:

1. It is quite impossible to return to "old-fashioned" values (and I include as old-fashioned all the current ideas which have their root in the 19th century or

before: Christianity, capitalism, liberalism and Marxism). These value systems no longer answer the questions which our age presents, although some of their basic ideas still have qualified validity.

2. The moral neutrality of science does not eliminate value judgments. As Professor Burtt put it, "value-free science has meant simply that the values dominating our thinking have retired to the arena of our underlying presuppositions."[4]
3. In a field like mental health, where certitude is rare and knowledge is cumulative, it is nearly impossible to be efficient without some basic convictions.

Alcoholism and Mental Health

How is this relevant to the field of alcoholism treatment? It is an accepted axiom among us that alcoholism is an illness, not a sinful indulgence due to weak will. This central axiom is supported by a multitude of satellite ideas, for example, that alcoholism is nearly always associated with emotional illness; that psychotherapy is an effective method in suring the alcoholic; that permissiveness, self-determination, a sense of confidence are essential in the treatment effort, and so on.

Obviously, the ethical systems implicit in this controversy are the Protestant ethic versus the Rationalistic ethic. Science is assumed to support the latter, although this is often debatable. If we continue to believe in reason, qualified by the same sort of occasional doubt and uneasiness as that of the last great social thinkers of the 19th century, then we have no choice but to assert this faith, seek support in facts and refrain from being dogmatic.

Dr. Lehrman's critique is valid, necessary and fortunately not isolated. There is a whole movement in the mental health field—Maslow calls it "the third force in psychology"[5]—which raises just these questions. But raising the questions and exposing the mistakes of others is just the first step. At present we have scientific basis for values, and it is not at all sure that science is the best source of values anyway. We are not very much farther along than Max Weber when he was holding that our initial values come from our individual experience and we have to labour to make them as rational as possible. In therapy, this means awareness of our own values, the patients' values, the common values of a given segment of society, rather than moral neutrality.

The Question of Values

Some thinkers, notably the European Existentialists and their more optimistic American pupils, gave a lot of thought to the question of values. Authenticity, decision, courage, the I and Thou relationship, care, engagement and commitment, are new formulations of values which are promising. Unfortunately, they are still very much investigated only on the individual and interpersonal level. The value problems of society are not solved.

There is a new trend in psychiatry —in social work it always existed— to look beyond the individual sufferer and see him in a social context. Ingenious methods of family therapy, group therapy and community therapy are elaborated. Again, we have no evidence that these methods are effective. As always in therapy we start from hunches and the faith that we are doing something worthwhile. We are as Foulkes and Anthony pointed out, "set between the proverbial horns. Too much science will kill therapy, too little science will reduce it to the status of faith healing."[6] Thus we must proceed from vagueness toward precision, from observation to accumulation of knowledge. Only in this way can we make sure that

our therapeutic activities will enrich the historical experience of the mental health field.

Max Weber himself declared that "an attitude of moral indifference has no connection with scientific objectivity",[7] as he attempted to transcend the mistakes of both positivism and idealism.

Certainly a diffuse and impatient humanism and arbitrary simplification of issues will not help. Questions of values pertain to the whole man in all aspects of his life as an end in himself, as well as a part of humanity, and the forging of a new ethical system will require hard-headed reasoning. But it will also require the attitude which existentialism emphasizes: we cannot comprehend man, we cannot understand the human situation unless we approach it with sympathy and compassion.

The mental health professions should draw on the classical values of Western humanism and translate them into a contemporary code of morality, into a "new scientific humanism." It is not at all necessary either to evade the problem of ethics or to mystify our patients by the magic of expertise.

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WHAT MAY I DRINK?

by E. M. CUTHBERTSON

Any drinking culture is dependent upon a slow process of learning and unlearning.

WE HUMANS are creatures of habit. Most of our habits are useful ones, reflecting that deeply learned control over the organization of behavior which functions in the interests of the body's economy. It would be a hopeless world if we had to learn all our activities anew each morning.

Now and then, something occurs in the life of an individual which necessitates a radical change, or removal of a well-organized habit. Any change of this kind is disrupting, and usually meets with a good deal of underground resistance from the habit owner.

To get rid of any habit, one must, of course, stop practicing it. This calls for deliberate thought. There must be constant interference between the desire to perform an act and its performance. If the habit one wants to remove has particular significance for us, then the interference process calls for tremendous energy and vigil. Learning theorists have suggested that one useful method of combatting an undesirable habit is to provide for substi-

tution of some other activity which meets the need to do something, and bridges that uncomfortable gap between abandoning an undesirable habit and learning a good new one.

Just such a problem faces the alcoholic. He has learned — some say 'over-learned'—the habit of drinking. When alcoholism develops he must stop drinking, thereby completely disrupting a strong, well-learned habit pattern. He also has to fight a deep psychological dependence upon alcohol. He has to revise his habit of thinking of himself as a drinker, and he has to learn to give a new response every time he feels like drinking. And he is a rank amateur at substitution.

One cannot drift from alcoholism into sobriety. At the beginning of recovery, the process of purposeful, thoughtful interference with the established habit of drinking must be a very active process indeed. Non-practice of the old habit of drinking calls for endless intervention in every kind of situation. Very often the alcoholic has developed a chronic emotional disturbance surrounding his drinking, so that his emotions may fail to support what his mind tells him is necessary.

What can the alcoholic person substitute for the alcohol which he has to surrender? Is he faced with a lifetime of dodging alcoholic drinks? The answer is yes. So far, science has not succeeded in rendering alcohol-intake safe for the alcoholic. He must turn to the use of non-alcoholic beverages. Anything else is skating on very thin ice indeed.

Many an alcoholic has sighed over the endless progression of soft drinks and coffee that come his way. Where once he could scan the beverage menu with pleasure, or cast a glad eye over the contents of his next-door neighbor's bar, now he hardly glances at it, knowing that, for him, all that is available is perhaps coke or ginger-ale.

Added to the fact that he may deplore the lack of variety available to him, is his emotional stress, created by the necessity of being different from his fellows. Different only in that he 'should not' drink alcohol. But what a painful difference this can be for the ego only the alcoholic knows. At all costs, however, the alcoholic must resist the temptation to slide back into the protective covering of 'normal' drinking.

In a public bar the waiter may look at him with scorn if he waves away the beer and asks for 'a juice.' In the more sophisticated cocktail lounge, the non-drinker has very little choice offered to him, and what choice he does have has no appeal. It does not come in an interesting-looking bottle. It has no sophisticated name to be ordered with pride, and generally, it does not even merit a special section on the menu. The non-drinker does not feel like 'the man of distinction.' He feels like 'the forgotten man.'

At any given time there are many adults in the population who, for one reason or another, don't wish to drink. Most of us have friends who don't drink, either permanently or occasionally. For this reason, all of us should acquaint ourselves with the many attractive beverages now on the market which do not contain alcohol, but which have real appeal for the palate.

There are many bottled drinks produced in Germany, France and England, as well as good domestic beverages from Canada and the United States.

Recently, one of our patient groups tried out a variety of non-alcoholic beverages, all of which are available in the grocery section of a large downtown department store. They found many of them to be pleasant to drink and commented that among them were drinks you

could 'stick with' for an evening. Some of the beverages had interesting names, such as Meier's Catawba, Lehr's Traubensoft and Cidro Mousseux. The group felt that they would like to see a section of cocktail menus which would include beverages of this kind.

It would be hazardous for the alcoholic to become very involved in trying to discover near-alcoholic drinks if all he is doing is pretending that he is drinking. He should view his selection of a non-alcoholic drink as a deliberate choice, and should enjoy it for what it is. He must re-educate his palate to appreciate non-alcoholic drinks.

Three great challenges face the recovering alcoholic. First, he must give up the use of alcohol altogether. Second, he must change his habit of thinking of himself as a drinker and learn to think of himself as a non-drinker. Third, he has to adapt himself comfortably to life in a culture where the majority of adults drink and he does not.

All three of these challenges call for an adjustment of habit patterns, and for a profound effort on the part of the recovering individual. He must prepare himself to persist in his efforts, regardless of whether or not society helps him by de-sensitizing his difference from others, or even by providing some pleasant substitute for him to drink.

On the other hand, a civilized society should not embarrass or exclude persons who do not or cannot drink alcohol, simply because of that fact. We should all be ready to encourage the listing of a variety of non-alcoholic beverages on menus, and hotel and restaurant proprietors should consider their non-drinking clientele. A good host, public or private, who is concerned with the well-being and comfort of his guests, will take pleasure in providing for the non-drinker with the same care he extends to the drinker. Why not try it and achieve the gratification of all your guests.

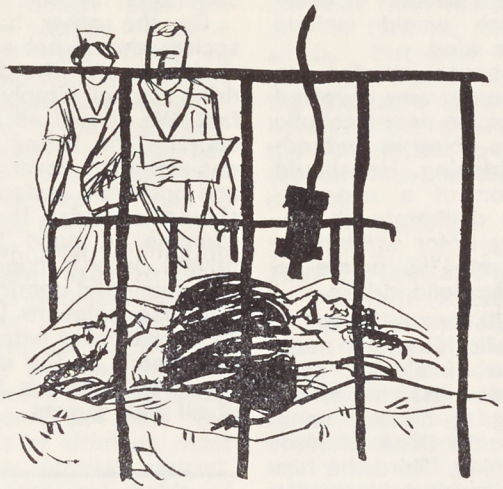
Miss Effie M. Cuthbertson, long a staff member of The Alcoholism Foundation of Alberta, has been concerned with Treatment, Group Therapy and lately Prevention and Education.

I have never for one instant seen clearly within myself; how then would you have me judge the deeds of others.

—Maurice Maeterlinck

MEDICAL

SURGERY IN ALCOHOLICS



DURING A BOUT, the alcoholic is likely to sustain injuries which may require an emergency operation, or the bout may bring to a head subacute conditions which then demand immediate surgery. But surgery in alcoholics presents two kinds of special and serious problems. On the one hand, the sudden termination of drinking through injury or hospitalization may precipitate an attack of delirium tremens—always a serious complication. On the other hand, a person who has used alcohol to excess for many years may have an increased tolerance to anaesthetic drugs, making it difficult to induce surgical anaesthesia.

Several recent reports deal helpfully with these problems. R. W. Grady and A. L. Rich (Fairfield, Ala.) describe the successful management of preoperative patients with hydroxyzine. An injection of 25 to 100 mg. of hydroxyzine in combination with atropine and pethidine produced a quieting effect without the depression usually observed with sedative drugs. In addition, nausea after the surgery was absent. Among 81 patients treated in this fashion who had to have emergency operations, 10 were under the influence of alcohol. All the intoxicated patients became co-operative and easy to manage when treated with hydroxyzine.

The possible complications which may arise in alcoholics when surgery is required are discussed by J. Baumann (France). Metabolic deficiencies, liver disease, and other conditions frequent in alcoholics may be exacerbated, increasing the surgical risk. On the whole, however, Baumann believes that this risk of alcoholics should not be over-estimated and that all necessary surgery should be undertaken

provided proper preoperative procedures are instituted. These include injections of vitamins, glucose and tranquilizers, as well as pethidine, barbiturates and diethazine, said to be a "vagolytic" drug. One hour before the operation a moderate intravenous injection of alcohol in glucose will prepare the alcoholic safely, provided he is not under treatment with disulfiram. In patients treated with disulfiram, thiopental and procaine should be used instead. Baumann recommends two avoidances: any surgery in patients severly ill with cirrhosis of the liver; and gastrectomy, if at all possible, in alcoholics.

The specific problem of delirium tremens in surgical patients has been tackled by A. Prigot and his colleagues (New York City). According to their experience, delirium tremens occurred sometime during hospitalization in 10 per cent of surgical patients. It usually happens in persons who, in addition to a history of excessive alcohol intake, have lived on a substandard diet, deficient in proteins and vitamins. The onset of delirium follows a period of stress, such as injury, acute infection, or the challenge of a surgical procedure. Not only is delirium tremens in itself a dangerous disease, but its occurrence in surgical patients creates a special problem in that it may mask the presence of other complications and thus prevent or delay their correction. This may lead to irreversible pathology and death.

The solution devised by Prigot and co-workers was the intravenous administration of the amino acids l — monosodium glutamate, l — arginine, and l — arginine — l — glutamate, and the amino sugar, n acetyl — d — glucosamine. When patients facing emergency operations were found to have low levels of amino acids, administration of these substances prevented the outbreak of delirium. If patients were admitted with delirium or developed it during hospitalization, treatment with aminco acids shortened the duration of delirium from an average of 4.4 days to an average of 2. The need for sedation was also reduced greatly. With this treatment, these investigators write, it should be possible to perform emergency operations in alcoholics without exposing them to the additional danger of delirium tremens.

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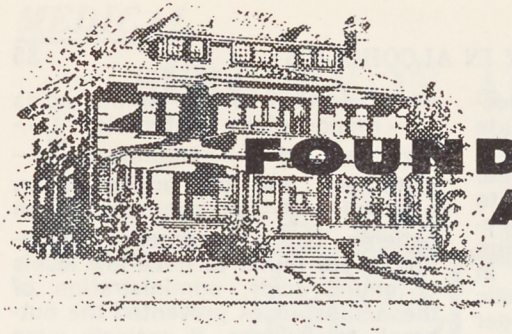
The heart to conceive, the understanding to direct, or the hand to execute.



FOUNDATION ACTIVITIES

SPRING, 1963

TREATMENT

The increased activity reported in the March issue has continued and attendance at our various groups has remained high. There has been a greater number of counselling interviews during the last quarter than ever before in the history of The Foundation. It is now evident that the increased demand for services is not of a temporary nature and we can look forward to a continued level of activity well above that which we have experienced in the past. Further developments in our group therapy will be occurring in order to meet this need.

RESEARCH

Most projects initiated in the first quarter of this year have been brought to a successful conclusion. The preliminary survey of skid row delineated boundaries and revealed characteristics of population and land use that warrant further investigation. The study of deaths among Foundation patients confirmed the reports of significantly higher mortality among alcoholics and indicated that 75% of the causes were other than 'natural'. Only 20% of the cases surveyed were abstinent at the time of death.

EDUCATION

During the past four months our teaching, public education and prevention programs have continued to be very brisk. Medical students, psychiatric internes and residents, nurses, both graduate and undergraduate, and other medical groups all received instruction in alcohol problems from Foundation staff. Many community organizations heard Foundation speakers, or joined in group discussions about alcohol use and alcoholism. Among these groups were the Y.M.C.A., the Junior League of Edmonton, St. Augustine's W.A. of Lethbridge, and several Home and School organizations. Staff members at all centres are very active in health, welfare and civic community groups. Of special interest were a Seminar held in April for the Calgary Council of Churches, and a visit by two Edmonton staff members to Ft. St. John, Dawson Creek and Whitehorse in the Yukon Territories at the invitation of local medical groups in that area.

OTHER FOUNDATION SERVICES

- **ADVISORY SERVICES:**
  Professional advice and assistance on the problems of alcoholism

- **AUDIO-VISUAL AIDS:**
  Films, tapes, records and displays are available on loan

- **CONFERENCES and SEMINARS:**
  To create a better understanding of the problems of alcoholism and methods of dealing with those problems

- **INDUSTRIAL WORKSHOPS:**
  For the education of management, supervisory staffs and general employees in Alberta industry

- **ORIENTATION PROGRAMS:**
  For nurses, doctors, internes, penal officials, personnel managers, social workers, clergymen, teachers and other groups

- **PUBLICATIONS:**
  Progress, Digest on Alcohol Studies and original brochures and pamphlets

- **REFERENCE LIBRARY:**
  Books, pamphlets and publications by authorities in the field of alcoholism

- **SPEAKERS' BUREAU:**
  For professional, industrial, church, social, school, civic and other groups requesting information

The illustrations in Progress are by Harry Heine

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